BALBOA VETERINARY MEDICAL CENTER

OWNER INFORMATION

First Name _____ Last Name _____

Spouse/Other _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone #1 _____

Work Phone _____ Cell Phone #2 _____

*Email _____ Client's D.O.B _____

Drivers License # _____ State: _____

How did you hear about us? (please cirlce)

Internet / Yelp / Google / Other _____ / Referral _____

NEW PATIENT INFORMATION

Pet's Name_____ **Species:** ☐ Dog ☐ Cat

Age/DOB: _____ **Breed**: _____ **Color**: _____

Sex: ☐ Male ☐ Female **Spayed or Neutered:** ☐ Yes ☐ No

Name of previous Doctor/ Clinic: _____

Approximate date of last vaccines: _____

Vaccinations received (please circle all appropriate):

Dogs: Rabies / Distemper / Parvo / Bordetella (Kennel cough)

Cats: Rabies / Distemper (FVRCP) / Leukemia (FeLV)

Other important medical history (allergies, diseases, surgery, etc.):

_____

Is your pet on a ***Flea preventative?*** (please circle): Yes / No

Heartworm preventative? (please circle): Yes / No

Other pets in household? Name: _____ Species:_____

Name: _____ Species:_____

Name: _____ Species:_____

BALBOA VETERINARY MEDICAL CENTER

☐ I do hereby give Balboa Vet. Med. Center, permission to obtain copies of my pet's medical records.

Signature of Owner/Authorized Agent _____ Date _____

Print of Owner/Authorized Agent _____

☐ **PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.**

I request that Balboa Veterinary Medical Center doctors and team perform the services which are necessary to the examination and medical treatment of the animal(s) presented by me. I am the owner or agent for the owner of the described animal(s) and have authority to execute this consent. Provider is hereinafter understood to mean Balboa Veterinary Medical Center, its veterinarians, agents, and employees.

I authorize the veterinarians on duty (and assistants they may designate) to examine the animal(s) and to administer medical treatment or emergency care which is considered therapeutically and/or diagnostically necessary on the basis of the examination findings. I, therefore, hereby consent to and authorize the performance **of** such procedures as deemed necessary and desirable in the veterinarian's professional judgment.

I understand that the treatment of the patient(s) will be conducted with due care and in accordance with the prevailing standards of care in veterinary medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the Provider. Accounts over 30 days past due shall pay interest at the maximum legal rate. I agree to pay all attorney fees,interest, collection costs and other costs of litigation incurred in the collection of past due accounts. The Provider shall not be responsible for the loss, theft or destruction of any personal property left with mypet(s).

I understand that a treatment plan may be provided at my request. I also consent to the release of medical information to other authorized veterinary and/or boarding facilities.I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon discharge.

I permit and authorize Balboa Veterinary Medical Center and it's employees, agents, and personnel who are acting on behalf of the Hospital to use my pet's photograph and first name for purposes related to the business of the Hospital, including publicity, marketing, and promotion of the Hospital & it's various websites, including social media.

I authorize any person with possession of the described animal(s) in addition to myself to request veterinary care for the described animal(s) and have the authorization to make medical decisions for the described animal(s) in my absence. In addition, I understand all services/products rendered by that person will be my financial responsibility.

Signature of Owner/Authorized Agent _____ Date _____

Print of Owner/Authorized Agent _____

Please note: *Your privacy is important to us. All information received in all forms and through communications is subject to our Patient Privacy Policy.*

NEW PATIENT INFORMATION

Pet's Name_____ **Species:** ☐ Dog ☐ Cat

Age/DOB: _____ **Breed**: _____ **Color**: _____

Sex: ☐ Male ☐ Female **Spayed or Neutered:** ☐ Yes ☐ No

Name of previous Doctor/ Clinic: _____

Approximate date of last vaccines: _____

Vaccinations received (please circle all appropriate):

Dogs: Rabies / Distemper / Parvo / Bordetella (Kennel cough)

Cats: Rabies / Distemper (FVRCP) / Leukemia (FeLV)

Other important medical history (allergies, diseases, surgery, etc.):

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Is your pet on a ***Flea preventative?*** (please circle): Yes / No

Heartworm preventative? (please circle): Yes / No

Other pets in household? Name: _____ Species:_____

Name: _____ Species:_____

NEW PATIENT INFORMATION

Pet's Name_____ **Species:** ☐ Dog ☐ Cat

Age/DOB: _____ **Breed**: _____ **Color**: _____

Sex: ☐ Male ☐ Female **Spayed or Neutered:** ☐ Yes ☐ No

Name of previous Doctor/ Clinic: _____

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Date